STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY VILLAGE NURSING HOME	3518 S SHELBY ST INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 7, 8, and 9, 2012. Facility number: 000142 Provider number: 155237 AIM number: 100266940 Survey Team: Karina Gates, BHS TC Beth Walsh RN Courtney Mujic, RN Barbara Hughes, RN Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 11 Medicaid: 67 Other: 12 Total: 90 Sample: 18 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 15,	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the Plan of Correction be considered the Letter of Credible Allegation on or after 03/01/2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2012 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure the supervisor and Administrator were notified immediately of an allegation of verbal abuse and failed	F0225	F225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found	03/01/2012

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	to report this allegation to the Indiana State Department of Health within 24 hours of staff reporting. The deficient practice affected 1 of 3 residents reviewed related to allegations of abuse in 3 facility abuse investigations reviewed for implementation of adequate abuse procedures. (Resident #32) Findings include: On 2/7/12 at 10:00 a.m., a report received by the Indiana State Department of Health on 10/11/11 was reviewed. The report written on 10/11/11 by the Director of Nursing (DON), indicated 4 days earlier on 10/7/11 at 7:00 a.m., CNA #4 reported that Resident #32 was verbally abused by LPN #5 four (4) days earlier, on 10/3/11 at 3:30 a.m. LPN #5 was interviewed and suspended on 10/7/11 pending investigation. On 2/9/12 at 3:00 p.m., the administrator provided a copy of information pertaining to the investigation of the above incident. Included in the information was an undated statement written by CNA #4 that was indicated to have been given to the Memory Care Coordinator on 10/7/11 around 7:00 a.m. The statement indicated "While assisting the nurse (name of LPN #5) in trying to get blood pressure on (name of Resident #32) the resident was		guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action	

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	combative to me hitting several times. When resident raised hand to strike the nurse (name of LPN #5) she told resident she would knock the s--- out of her." Review of the documentation of the telephone conversation that took place on 10/7/11 at 2:10 p.m., between LPN #5 and the DON and Administrator indicated "(Name of LPN #5) returned call. Asked if she was aware of any event that may have occurred with a resident on Memory Care (unit on which Resident #32 resided). She paused for a moment and said "No, not really...the only thing she could think of was (name of resident #32)...She was hitting and threatening to kill me. She said that she was going to kill me. She hit the CNA and she tried to hit me." Asked if she could have said anything else. She paused again and we asked if she could have said it using inappropriate language. She said "No. Well, I think I told her to cut that s--- out...I know that I shouldn't have said it and I feel bad." Discussed the meaning of abuse and could this not be construed as abuse. "I have never abused any of my residents...I have never abused anyone with Dementia or anyone." Asked if she sees how using offensive language could be construed as abuse. I guess that it could, but I never would abuse anyone." Review of the documentation immediately proceeding the telephone		must be taken. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #32 was followed by Memory Care Coordinator (MCC) and psychologist for any signs or symptoms of distress. · CNA #4 was interviewed and re-educated on reporting criteria. · LPN #5 was interviewed, suspended and is no longer employed by this facility. · Allegation was reported to Indiana State Department of Health (ISDH) on 10/11/2011 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All resident have the potential to be affected. · Staff members report allegations of abuse to the supervisor and Administrator immediately. · The Administrator/Director of Nursing reports allegations of abuse to the ISDH within 24 hours of becoming aware of an allegation of abuse. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Executive Director (ED) inserviced Department Managers 02/22/2012 regarding reporting criteria and timeline. · Nursing staff was inserviced with posttest on or before 03/01/2012	

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	conversation indicated "Following the interviews we were unable to determine the correct version of what was said. We contacted (name of LPN #5) and informed her the investigation was inconclusive and she would be allowed back at work with a final written warning..." Review of the timecard for LPN #5 indicated she returned to work that same night of 10/7/11 at 10:53 p.m., and worked until 8:13 a.m. on 10/8/11. During interview with the DON on 2/9/12 at 12:50 p.m., she indicated the reason the results of the investigation were inconclusive was because they tried not to do a "he said, she said". She indicated LPN #5 was not terminated as a result of the abuse allegation/investigation, but was terminated soon after because of her attendance. She indicated there was no explanation as to why this allegation was not reported to the Indiana State Department of Health timely. The "Abuse Prohibition Review" was provided by the DON on 2/9/12 at 2:30 p.m. and reviewed at this time. It indicated CNA #4 was interviewed on 10/7/11 and 10/12/11, no times indicated. The notes section stated, "Yes, I gave you my statement. Asked why the delay in reporting. Stated that at a previous job		by the ED/ Director of Nursing Services (DNS) regarding reporting criteria and timeline to report. · Inservices with posttest regarding Abuse are held in orientation and no less than twice a year. · ED/Qualified Designee will interview staff members on all three shifts periodically to ensure understanding about abuse and abuse reporting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Abuse Prohibition and Investigation* Continuous Quality Improvement (CQI) tool weekly x 4, bi-monthly x 2 months, and then quarterly x's 2 with results reported to the CQI committee overseen by the ED until determined during CQI meeting the audits are no longer required based on a threshold of 100 percent. If threshold is not achieved an expanded action plan will be developed to ensure compliance.	

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	she had reported someone and that person then threatened and stalked her. "I was afraid, but I knew that I couldn't let it go."" 3.1-28(c)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			
	Based on interview and record review, the facility failed to ensure the supervisor and Administrator were notified immediately of an allegation of verbal abuse per facility policy and failed to report this allegation to the Indiana State Department of Health within 24 hours of staff reporting per facility policy. The deficient practice affected 1 of 3 residents reviewed related to allegations of abuse in 3 facility abuse investigations reviewed for implementation of adequate abuse procedures. (Resident #32) Findings include: On 2/7/12 at 10:00 a.m., a report received by the Indiana State Department of Health on 10/11/11 was reviewed. The report written on 10/11/11 by the Director of Nursing (DON), indicated 4 days earlier on 10/7/11 at 7:00 a.m., CNA #4 reported that Resident #32 was verbally abused by LPN #5 four (4) days earlier, on 10/3/11 at 3:30 a.m. LPN #5 was interviewed and suspended on 10/7/11 pending investigation. On 2/9/12 at 3:00 p.m., the administrator provided a copy of information pertaining	F0226	F226 483.13(c) DEVELOP/IMPLMENT, ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #32 was followed by Memory Care Coordinator (MCC) and psychologist for any signs or symptoms of distress. · CNA #4 was interviewed and educated on reporting criteria. · LPN #5 was interviewed, suspended and is no longer employed by this facility. · Allegation was reported to Indiana State Department of Health (ISDH) on 10/11/2011 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All resident have the potential to be affected. · Staff members report allegations of abuse to the supervisor and Administrator immediately. · The Administrator/Director of Nursing reports allegations of abuse to the	03/01/2012

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	to the investigation of the above incident. Included in the information was an undated statement written by CNA #4 that was indicated to have been given to the Memory Care Coordinator on 10/7/11 around 7:00 a.m. The statement indicated "While assisting the nurse (name of LPN #5) in trying to get blood pressure on (name of Resident #32) the resident was combative to me hitting several times. When resident raised hand to strike the nurse (name of LPN #5) she told resident she would knock the s--- out of her." Review of the documentation of the telephone conversation that took place on 10/7/11 at 2:10 p.m., between LPN #5 and the DON and Administrator indicated "(Name of LPN #5) returned call. Asked if she was aware of any event that may have occurred with a resident on Memory Care (unit on which Resident #32 resided). She paused for a moment and said "No, not really...the only thing she could think of was (name of resident #32)...She was hitting and threatening to kill me. She said that she was going to kill me. She hit the CNA and she tried to hit me." Asked if she could have said anything else. She paused again and we asked if she could have said it using inappropriate language. She said "No. Well, I think I told her to cut that s--- out...I know that I shouldn't have said it and I feel bad." Discussed the meaning of		ISDH within 24 hours of staff reporting. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**· The Executive Director (ED) reviewed the ***ABUSE PROHIBITION, REPORTING, AND INVESTIGATION*** *POLICY AND PROCEDURE* then inserviced Department Managers 02/22/2012 regarding reporting criteria and timeline. · Staff members were inserviced with posttest on or before 03/01/2012 by the ED/ Director of Nursing Services (DNS) regarding ***ABUSE PROHIBITION, REPORTING, AND INVESTIGATION*** *POLICY AND PROCEDURE*. · Inservices with posttest regarding Abuse are held in orientation and no less than twice a year. · ED/Qualified Designee will interview staff members on all three shifts periodically to ensure understanding about abuse and abuse reporting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Abuse Prohibition and Investigation* Continuous Quality Improvement (CQI) tool weekly x 4, bi-monthly x 2 months, and then quarterly x's 2 with results	

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	abuse and could this not be construed as abuse. "I have never abused any of my residents...I have never abused anyone with Dementia or anyone." Asked if she sees how using offensive language could be construed as abuse. I guess that it could, but I never would abuse anyone." Review of the documentation immediately proceeding the telephone conversation indicated "Following the interviews we were unable to determine the correct version of what was said. We contacted (name of LPN #5) and informed her the investigation was inconclusive and she would be allowed back at work with a final written warning..." Review of the timecard for LPN #5 indicated she returned to work that same night of 10/7/11 at 10:53 p.m. and worked until 8:13 a.m. on 10/8/11. During interview with the DON on 2/9/12 at 12:50 p.m., she indicated the reason the results of the investigation were inconclusive was because they tried not to do a "he said, she said". She indicated LPN #5 was not terminated as a result of the abuse allegation/investigation, but was terminated soon after because of her attendance. She indicated there was no explanation as to why this allegation was not reported to the Indiana State Department of Health timely.		reported to the CQI committee overseen by the ED until determined during CQI meeting the audits are no longer required based on a threshold of 100 percent. If threshold is not achieved an expanded action plan will be developed to ensure compliance.	

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	The "Abuse Prohibition Review" was provided by the DON on 2/9/12 at 2:30 p.m., and reviewed at this time. It indicated CNA #4 was interviewed on 10/7/11 and 10/12/11, no times indicated. The notes section stated, "Yes, I gave you my statement. Asked why the delay in reporting. Stated that at a previous job she had reported someone and that person then threatened and stalked her. "I was afraid, but I knew that I couldn't let it go."" The facility's abuse policy was provided by the Administrator on 2/7/12 at 11:00 a.m. The policy indicated, "All allegations/abuse must be reported to the Executive Director immediately...It is the responsibility of the Administrator/DON to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of Health...Any individual who witnesses abuse, or has suspicion of, shall immediately notify the charge nurse of the unit, which the resident resides." 3.1-28(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow physician's orders for 1 of 8 residents reviewed for lab completion and 1 of 1 residents reviewed for splint application, in a total sample of 18 (#79, #52). Findings include: 1. The clinical record for Resident #79 was reviewed on 2/7/12 at 1:30 p.m. The diagnoses for Resident #79 included, but were not limited to: osteoporosis, degenerative joint disease, osteoarthritis, and history of left knee and left hip replacement. A recapitulation of the February Physician's Orders indicated that bilateral foot/ankle splints were to be on while in bed. There was a clarification of the above order on 2/8/12 that indicated boots were to be on while in bed. A care plan, dated 1/4/12, for impaired skin integrity had an approach for the use of foot splints, to help the resident's wounds be free from signs of	F0282	F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #79 was screened by therapy for appropriate splint application, physician was notified, care plan and CNA assignment sheets are updated. · Resident #52's physician was notified and BMP drawn on 02/09/2012 and 02/16/2012 with results reported to physician. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who wear splints have the potential to be affected. · Resident's who wear splints were screened by therapy and wear splints based on physician orders. Care plans and CNA assignment sheets are updated. · Residents with laboratory orders have the potential to be affected. · Residents with laboratory orders have labs drawn based on physician orders. **What**	03/01/2012

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	complications. During an observation on 2/8/12 at 2:30 p.m., the resident was asleep in bed with the splints beside the bed. LPN #2 indicated the resident is to have the splints on while in bed. She indicated the splints were just taken off and will only be off for a half hour, since the resident was tugging at the splints and seemed irritated by the splints. During an observation on 2/8/12 at 3:50 p.m., the resident was asleep in bed with the splints beside the bed. During an observation on 2/8/12 at 4:30 p.m., with the LPN #1, the resident was asleep in bed with the splints beside the bed. LPN #1 indicated that the splints were to be on while the resident is in bed and then she proceeded to put the splints on the resident. 2. The clinical record for Resident #52 was reviewed 2/8/12 at 11:55 a.m. The diagnoses for Resident #52 included, but were not limited to: diabetes mellitus, cellulitis, osteomyelitis, wounds, and septicemia. A recapitulation of the physician's orders indicated that an order was written on		**measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**· The Director of Nursing (DNS) inserviced with posttest nursing staff on or before 03/01/2012 regarding splint application and referencing *Resident Care Sheets.* · Nurses verify splint placement on nursing rounds. · Nurse Managers reviewed all routine lab draw orders and verified that they are on the laboratory draw schedule. · Assistant Director of Nursing (ADNS) reviewed and recorded next lab draw dates on lab tracking form. · New lab orders are reviewed by nurse managers in the Interdisciplinary Team meeting at which time it is verified that new labs are ordered and/or confirmed that results are received. · Nurses were inserviced on 02/16/2012 by laboratory account manager on ordering labs and obtaining results. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Splints* and *Labs/Diagnostics* Continuous Quality Improvement (CQI) tool weekly x 4, bi-monthly x 2 months, and then quarterly x's 2 with results reported to the CQI committee overseen by the ED	

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	1/23/12 for weekly BMPs (Basic Metabolic Panel) for 3 weeks and every 3 months thereafter. The last results for a BMP was 1/24/12. In an interview with the DoN (Director of Nursing) on 2/9/12 at 10:40 a.m., she indicated there was a miscommunication with the lab and the other two weekly labs were not completed. She also indicated that there was breakdown with the facility's lab reconciliation process. 3.1-35(g)(2)		until determined during CQI meeting the audits are no longer required based on a threshold of 100 percent. If threshold is not achieved an expanded action plan will be developed to ensure compliance.	

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review and interview, the facility failed to ensure a resident was positioned at the correct bed height for the administration of medicines by feeding tube. This affected 1 of 1 resident requiring a feeding tube out of a sample of 18. (Resident # 85) Findings include: During an observation on 2/8/12 at 4:05 P.M., LPN #3 administered medications to Resident #85 (by feeding tube) with the bed in a position lower than 30 degrees (as required by physician's order). The resident started coughing and gagging. During an interview at 4:10 P.M., LPN #3 indicated the resident does cough and gag sometimes and it was not unusual Black tape was observed on the headboard of the bed and also on the bottom of the bed frame. The bed frame was observed to be approximately 6 inches lower than the black tape on the headboard.	F0322	F322 483.25(g)(2) NG TREATMENT/SERVICES -RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #85 head of bed elevation was recalibrated by Maintenance Director to ensure proper elevation. · LPN #3 was re-educated on how to determine the proper bed height. Speech therapy evaluated Resident #85 due to concerns over gagging and coughing during medication administration. It was determined that resident has oral and pharyngeal dysphagia and safely receives nutrition/hydration from GT.	03/01/2012

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	Review of Resident 85's record on 2/9/12 did not indicate any episodes of coughing or gagging. Resident #85's current diagnoses included but were not limited to cerebral palsy, quadriplegia, aphasia and dysphagia. A Physician's order, dated 2/1/12, indicated that Resident #85's bed should be elevated 30 to 45 degrees for the administration of medications. On 2/9/12 at 2:00 P.M., during an interview, the ADON indicated that the black tape on the headboard of the resident's bed should line up with the black tape on the bed frame. If the tape was not lined up, the bed was in a position lower than 30 degrees, as required for medication administration. The ADON indicated she would conduct training to staff about the tape indications for proper bed height of 30 degrees. 3.1-44(a)(2)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Resident's requiring gastrostomy tube (GT) feedings and GT medication have the potential to be affected. · Resident's requiring GT feedings and GT medication receive the appropriate treatment per physician order and services to prevent complications. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**· GT resident beds were remarked using a narrower more easily identifiable tape. · The Director of Nursing (DNS) ordered 10 inclinators on 02/17/2012 with anticipated delivery of 02/23/2012. Maintenance Director to apply inclinators to beds. · DNS inserviced staff with posttest on or before 03/01/2012 regarding how to identify 30° based on tape markings on the head of bed. Reinservicing regarding the use of the inclinator will be completed prior to installation. · Nurses verify head of bed elevation during rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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			The DNS/Qualified Designee is responsible for the completion of the *Enteral Therapy* Continuous Quality Improvement (CQI) tool weekly x 4, bi-monthly x 2 months, and then quarterly x's 2 with results reported to the CQI committee overseen by the ED until determined during CQI meeting the audits are no longer required based on a threshold of 100 percent. If threshold is not achieved an expanded action plan will be developed to ensure compliance.	

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F0412 SS=D	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.			
	Based on observation and interview, the facility failed to ensure a resident with missing dentures had been scheduled for a follow-up dental appointment. This affected 1 of 1 resident reviewed for dental care in the sample of 18. (Resident # 82) Findings include: On 2/9/12 at 2:20 P.M., Resident #82 was interviewed and indicated she was missing her bottom dentures and had been requesting new teeth be provided by the facility for a long time but nothing had been done. She indicated she eats a regular diet and stated "I eat it anyway I can." During an interview with the ADON (Assistant Director of Nursing) and Social Services Director (SSD) on 2/9/12 at 2:35 P.M., the ADON indicated she was not aware of any missing dentures. The SSD obtained information from the facility's	F0412	F412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #82 was seen by the dentist on 02/14/2012 to start the process for lower denture replacement. Speech therapy screened resident on 02/21/2012 and stated that resident has no difficulty with eating. Resident had impressions made 02/21/2012. **How will you identify other residents having**	03/01/2012

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	computer indicating that Resident #82 was seen by a dentist on 3/18/11 who indicated this resident needed new dentures consisting of both the upper and lower plates. The SSD also indicated she could not find any other record of the dentures being made or delivered. On 2/9/12 at 2:40 P.M., the SSD was observed viewing Resident #82's mouth and indicated she did not see any lower plate dentures. During an interview with the SSD on 2/9/12 at 3:30 P.M., she indicated she had done some research and found that the resident did not have any insurance in effect until 10/1/11 and that an appointment had been scheduled for her to have impressions made for dentures on 11/9/11, but that Resident #82 was out of the facility on that day and that nothing has been done since that time. 3.1-24(a)(3)		**the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents with lost or damaged dentures have the potential to be affected. · Residents with lost or damaged dentures are promptly referred to a dentist. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**· Social Services set up two alternative dentists that have agreed to see any of our residents who require emergency dental services. · Residents with dentures were assessed for presence and fit of dentures. · Residents with missing or ill fitting dentures were referred to Social Services to set up dental services. Dentist is here 02/23/2012. · Resident Care sheets reflect denture use. Certified Nursing Assistants report when dentures are lost or damaged. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Dental Services* Continuous Quality Improvement (CQI) tool weekly x 4, bi-monthly x 2 months, and then quarterly x's 2 with results reported to the CQI committee overseen by the ED until determined during CQI	

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			meeting the audits are no longer required based on a threshold of 100 percent. If threshold is not achieved an expanded action plan will be developed to ensure compliance.	

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F0496 SS=D	Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. Based on interview and record review, the facility failed to ensure an employee who was working as a nurse aide since May, 2011, was registered with the Indiana State Department of Health as a nurse aide. (Employee #6)	F0496	F496 483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the	03/01/2012

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	Findings include: The employee record for Employee #6 was reviewed on 2/9/12 at 11:30 a.m. The records indicated her job position was a CNA (Certified Nurse Aide), but no license could be found in the employee's file. During an interview with the Executive Director on 2/9/12 at 1:25 p.m., he indicated Employee #6 did not pay the fee to take the state test to become a CNA and is not on the state's registry. He indicated Employee #6 began working as a CNA in May, 2011. 3.1-14(e)(2)		individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e) (2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Employee #6 was immediately removed from the nursing schedule. **How will you**	

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			identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Residents requiring nursing care have the potential to be affected. · All Certified Nursing Assistance (CNA) have current certification. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**· Nursing Scheduler did full audit for all CNAs and certifications are current and present. · Home Office consultant reviewed and verified current CNA certifications. · Home Office consultant assisted nursing scheduler to establish a system to ensure certifications are consistently maintained and current. · Nursing scheduler keeps the CNA certifications in a binder arranged by month; the certifications are reviewed prior to the 1 st of each month to remind CNAs of the date for their recertification. The date is recorded on a monthly calendar that is checked daily. CNAs are promptly removed from the schedule if verification of current certification is not received prior to the required date **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Qualified Designee is responsible for the completion of the *Employee Files* Continuous Quality Improvement (CQI) tool weekly x 4, bi-monthly x 2 months, and then quarterly x's 2 with results reported to the CQI committee overseen by the ED until determined during CQI meeting the audits are no longer required based on a threshold of 100 percent. If threshold is not achieved an action plan may be developed to ensure compliance.	